THE RECOVERY KERNEL

Critical Methodology Series

THE ADDICT VIRGIN PROBLEM

Varför evidensbasen byggdes för någon annan –
And what interventions look like when they're tailored to you:

*** [List of interventions]**

Including the nootropic stack that was left out — and shouldn't have been.

Each suggestion found in typical addiction recovery materials was developed based on groups of people who didn't experience the same challenges as you do.

The yoga content is designed for people who are sober.
The meditation content is suitable for people who are stressed but not overwhelmed.
The exercise content is appropriate for individuals who are mildly addicted or newly sober.
None of the content is intended for people with a history of long-term methamphetamine use.

This document is the straightforward version, written for someone whose system has been compromised. The interventions have been adjusted to reflect your current situation. Any previously omitted nootropics are now included. The timeline has been revised based on your specific circumstances.

I. The Addict Virgin Problem — Naming the Flaw in the Data

◆ The standard evidence base for recovery was built upon an inappropriate population and for an incorrect purpose.

When a study reports that 'yoga reduces cortisol and improves prefrontal function in addiction recovery,' the study population is typically one of three things:

* People who were stressed but not addicted.
* People who had mild to moderate addiction and have been sober for 60-90 days, with no protocol other than cessation.

* People in structured inpatient programs who are receiving nutrition, sleep, and social support simultaneously — making it impossible to attribute the effect to the yoga.

the person with 10 years of heavy methamphetamine use, 3 years of daily GHB, 5 overdoses requiring intubation, significant dopaminergic terminal damage, severe anhedonia, and profound prefrontal volume reduction who shows up to a yoga class 30 days sober with a dopamine system that cannot generate the reward signal that makes yoga self-sustaining.

The study didn't study that person. The recommendation for that person was built by extrapolation from data that doesn't include them. This is not scientific fraud — it is the standard limitation of research that studies the accessible population (mild to moderate, agreeable to participation, medically stable) and gets cited for the inaccessible population (severe, chaotic, physiologically decimated). The limitation is real and it matters enormously for what we recommend and what timelines we set.

The Addict Virgin evidence base assumes:	**The actual severe addiction recovery person has:**
Un sistema de recompensas que produce una respuesta neurológica básica de recompensa a partir de actividades positivas. El yoga se siente bien porque la serotonina, las endorfinas y las respuestas del sistema nervioso parasimpático están disponibles en niveles básicos.	Severe anhedonia — D2 receptor downregulation means the baseline reward response to positive activities is blunted or absent. Yoga may feel like nothing for weeks. Not unpleasant. Not pleasant. A sensory void where the reward should be.
Motivazione che nasce dall'interno ed è auto-sostenibile. La persona continua la pratica perché si sente meglio grazie ad essa. La ricompensa è il meccanismo di mantenimento.	Motivation that requires external support because the internal reward system isn't strong enough to keep the practice going. Someone who doesn't experience any benefit from yoga in week one might stop by week two, as there's no neurological reinforcement to sustain their involvement.
Un sistema propioceptivo-motor calibrado para el estado sobrio. El cuerpo se siente como uno mismo durante la práctica. El movimiento es natural y coordinado en el contexto que se está practicando.	A tachyon system calibrated to the substance state. The sober body feels foreign. Movements that were always made in the substance-calibrated state feel off, effortful, or alien in the ungroomed sober state.
Social comfort in group settings. The yoga class provides a positive social environment that enhances the practice.	High social anxiety and shame, particularly in contexts where the person is visibly struggling with something that other participants find easy. The yoga class may feel like a performance of failure in front of witnesses.

Un'aspettativa temporale calibrata sulla popolazione: "8 settimane di yoga producono una riduzione misurabile del cortisolo". Questo è accurato per la popolazione studiata.	Un calendrier qui peut être 2 à 3 fois plus long pour un système gravement affaibli avant que les mêmes effets ne soient obtenus. Les données de réduction du cortisol sur 8 semaines ne sont pas fausses, elles ne conviennent pas au point de départ de cette population.

The failure mode: a severely addicted person tries yoga for 3 weeks, feels nothing, concludes that yoga doesn't work for them specifically, adds this to the growing evidence that nothing works for them, and stops. The study that showed yoga works was not done on this person. The failure was predicted by the data's population bias. But the person carries it as personal failure.

1.1 — The Half-Assed Destination Problem

JR Token's framing is precise: sobriety is recommended as a destination when it is actually a source condition. The recovery literature treats sobriety as the achievement — get sober, then life improves. But the person with severe addiction who achieves sobriety arrives at a starting point, not a destination: a biologically devastated body, a socially damaged network, a financially depleted position, a professionally interrupted trajectory, and a dopamine system that cannot reward the work of rebuilding any of these things.

The interventions recommended from that starting point are calibrated to a sober person's capacity — the exercise tolerance, the motivational capacity, the social comfort, the timeline expectations. They are borrowed from a different person's experience and applied to this person's reality. The result is an 80% relapse rate that we misattribute to the addiction's power when it is at least partly attributable to the mismatch between the recommendation and the population.

What the person actually needs is not the sober person's yoga. It is the addicted-person-strength version of each intervention — calibrated to the damaged system's actual starting capacity, with honest timelines, with the specific tools that address the specific damage, and with explicit acknowledgment that the first weeks will feel like nothing and that this is expected and normal, not a sign of personal failure.

FROM THE MOUTHPIECE

Written from the soul of the persons who would have, if they could have.

A Letter From the People Who Tried.

We gave yoga a go.

We attended the class. We laid out our mats. We performed the exercises. We breathed into the poses as instructed by the teacher. We waited for the calmness, clarity, sense of presence, and wellbeing that everyone said it would bring. And we felt: nothing. A body in motion. A mind observing the body's movements. The same emptiness where something used to be, disguised in athletic wear.

We tried three times. Four. The teacher said to be patient, that the practice would grow. What grew was the awareness of how different we were from everyone else in the room. They sighed contentedly after savasana. We stared at the ceiling wondering if this was what the rest of our life was going to feel like. Empty exertion in a room full of people who had something we didn't have yet and might never have again.

Nobody told us that the yoga was designed for them, not us.

Nobody said: your dopamine system cannot produce the reward that makes this practice self-sustaining yet.
Nobody said: the study that showed this works was done on people whose reward circuits were intact.
Nobody said: for you, it might take three months before the first session produces something that feels like what they feel after one.
And that's not failure. That's arithmetic. The starting point is different. The timeline is different. The experience is different.

Nobody said any of that. They said keep coming. As if showing up to collect nothing was a spiritual practice. As if the endurance of emptiness was the point rather than a bug in the recommendation.

We tried the meditation. The twenty minutes of breath focus. We'd sit down and our mind would go to the substance. To the absence of the substance. To the memory

of what having the substance felt like. Twenty minutes of intimate contact with precisely what we were trying to put distance from, with none of the tools that would make that contact manageable, guided by an instruction that was designed for someone who wasn't doing that.

We tried the exercise. We pushed ourselves to the gym in the first few weeks when our motivation was pharmacologically impossible, when the dopamine anticipation that makes future-oriented behavior possible was depleted, when our body felt foreign and wrong. We did it anyway because the literature said it would help. It did help. But the help was delayed past the point where most of us could wait for it, and nobody warned us about the delay. They just said exercise helps. Not: exercise will feel like forced labor for six weeks before it produces anything. Not: the reward system that makes Exercise and self-sufficiency are things that your addiction has likely harmed, so the first six weeks will be a particular challenge, but it's one that can be overcome.

We were working with faulty equipment and attempting to use it to troubleshoot its own issues. This was done without a clear understanding of how the equipment should perform when it's malfunctioning and undergoing repairs.

What we needed was someone to say:

Your starting point is different from the person the study was done on. Your timeline is longer. Your experience in the first weeks will be emptier. This is not a sign that you are unfixable. It is a sign that you are starting from a deeper deficit, which means the journey to the middle is longer, not that the middle doesn't exist.

The interventions work. They work more slowly for you. The yoga will eventually produce what it produces for the sober person, but it will take three months, not three weeks. Keep going past the point where you feel nothing, because the point where you feel nothing is exactly where the damaged person quits and exactly where the undamaged person is just starting to feel it.

And: there are tools specifically built for damaged brains that we are not giving you, because the people who designed the program are treating your brain like a sober brain that needs behavioural support, not a structurally damaged brain that needs specific pharmacological and nutritional scaffolding while the behavioural support has time to work.

Give us those tools. Tell us what is actually broken and what specifically fixes each broken thing. Stop borrowing recommendations from the population that never had what we have. Build the protocol for the actual starting point, not the aspirational one.

We would have, if we could have. We're asking you to help us make it possible.

II. Intervenciones centradas en las fortalezas de la persona con adicción.

◆ The intervention is the same. The calibration is different. Significantly different.

Intervention.	The Addict Virgin version (what most programs offer).	The Addicted-Person-Strength version (what the damaged system needs).
Yoga / movement practice.	Come to class. The practice will build. After 8 weeks, you'll feel the benefits. Gentle hatha yoga in a group class. Savasana. Breathing. The class is designed for the person whose nervous system responds to these inputs.	High-heat power yoga or vinyasa (temperatures between 60-90°F) specifically designed for individuals whose reward system struggles to register mild sensations. The high physical intensity helps overcome anhedonia. This is not intended for enjoyment, but rather for stimulation at a level that the impaired system can detect. The format should be trauma-sensitive: no unexpected adjustments, and the instructor should have experience with substance recovery. Begin with a 3-5 minute session and gradually increase the duration. Inform the individual explicitly: "You may not feel anything for 4-6 weeks. This is expected. The absence of feeling indicates the extent of the deficit, not the ineffectiveness of the practice. Continue attending for 6 weeks before drawing any conclusions."
Meditation.	"Sit for 20 minutes and focus on your breath. Whenever your mind wanders, gently bring it back to your breath." This instruction assumes that the person can tolerate 20 minutes of experiencing their inner thoughts and feelings	2-5 minute maximum initial sessions. The anhedonic, craving, shame-saturated mind of early severe recovery cannot tolerate 20 minutes of its own unmediated experience. Starting at 2 minutes and building by 1 minute per week reaches 20 minutes in 18

	without medication, and that they won't be overwhelmed by cravings, shame, or withdrawal symptoms.	weeks — which is when the practice begins producing structural PFC change. The goal for the first 8 weeks is not benefit — it is tolerance. Building the tolerance to be present in the sober mind at all. Walking meditation for those who cannot sit: movement anchors the attention more effectively when the still mind is too confronting.
Aerobic exercise.	'30 minutes of moderate aerobic activity, 3-5 times per week.' This recommendation assumes the motivational architecture to sustain a practice that produces no immediate reward, the physical capacity for 30 minutes of aerobic effort after weeks of physical depletion, and the tolerance for the uncomfortable physical experience of exertion in a body that feels foreign.	10-minute minimum effective first dose. Not 30 minutes, 10. Get out of the building, walk fast for 10 minutes, return. The BDNF production curve shows meaningful production from 10 minutes of moderately vigorous activity. Establishing the daily 10-minute habit is the goal for weeks 1-4. Scale to 20 minutes in weeks 4-8. Reach 30 minutes at weeks 8-12. The person who failed to sustain a 30-minute program in week 1 was given the wrong first dose. The 10-minute daily walk at week 1 is the correct starting dose for the severely depleted system.
Social recovery support/group.	Attend group meetings. The community will support you. This is designed for people who can handle the social interaction, the emotional content of other people's stories, and the group dynamics without becoming distressed, without being negatively influenced by others, and without feeling ashamed because they are struggling with something that others seem to manage more easily.	Individual practitioner first, group later. The severely depleted nervous system, the high social anxiety of early recovery, the trauma reactivity, and the peer contagion risk all argue for 1:1 support before group. When group is introduced: heterogeneous stages (people at different distances from the substance) are significantly better than homogeneous early-recovery groups. The person who is 30 days sober in a room full of other people who are also 30 days sober is in a peer contagion environment. The person who is 30 days sober in a room with people who are at 6 months, 2 years, and 5 years

		has access to the reference points their recovery needs.
Nutrition.	"Eat balanced meals with adequate protein and micronutrients." This recommendation assumes the appetite regulation system is functional, the motivation to prepare food is available, and the financial resources for quality nutrition are present.	Nutritional rehabilitation as a clinical protocol: structured meal timing (eating by the clock, not by hunger, because hunger signals are disrupted in early recovery), protein-first at every meal (dopamine synthesis requires tyrosine and phenylalanine — every meal should begin with protein to provide substrate), and supplement delivery of specific nutrients that appetite dysregulation prevents adequate dietary intake of (B vitamins, zinc, magnesium, essential fatty acids).

II.1 — The Honest Timeline Adjustment

Les calendriers fondés sur des données probantes pour les interventions de rétablissement ont été élaborés auprès de populations "vierges" en matière de toxicomanie ou présentant une toxicomanie légère. Les ajustements suivants reflètent la réalité du calendrier de rétablissement pour les cas de toxicomanie sévère, lorsque le protocole est appliqué au point de départ réel :

Timeline claim.	The population on which it was measured.	Adjusted timeline for severe addiction.	What the adjustment reflects.
Exercise improves mood within 2 weeks.	Personas no adictas, adultos estresados o personas en las primeras etapas de recuperación leve con sistemas de recompensa intactos.	4-8 veckor innan en konsekvent förbättring av humöret märks. Längre tid för dopaminrelaterad skada som är specifik för stimulerande medel.	The reward system that registers "exercise improved my mood" requires DRD2 receptor density, which severe addiction has reduced. The improvement may be occurring physiologically before it is felt subjectively.
Meditatie levert	Non-addicted,	12-16 veckor vid	The 8-week data

aantoonbare vermindering van het cortisolgehalte na 8 weken.	stressed adults.	den startdos som är lämplig för personen med beroende (initiala sessioner på 2-5 minuter, med gradvis ökning). Övningen måste tolereras innan den kan vara till nytta.	assumes full-dose sessions from week 1. The addicted person's starting dose is a fraction of the full dose. The benefit timeline scales with the dose ramp-up.
Physical activity reduces cravings in early recovery.	Populations with 30-90 days of sobriety, moderate addiction severity.	True but the effect is smaller and more delayed for severe addiction. The craving reduction from exercise in the first 2-4 weeks may be insufficient to override the craving without simultaneous pharmacological support (NAC, methylation stack, and ideally nootropic support for the prefrontal capacity needed to act on the craving reduction).	The craving reduction from exercise requires the prefrontal cortex to act on the reduced craving signal. The prefrontal capacity that's required is exactly what severe addiction has specifically impaired. Exercise + nootropic PFC support together produce the effect that exercise alone is supposed to produce.

III. The Nootropic Stack for the Damaged Brain.

◆ These were left out. They should not have been. The AMPA receptor impairment of addiction is specifically what racetams address. This is not a coincidence.

The standard supplement stack in the Recovery Kernel (NAC, 5-MTHF, methylcobalamin, magnesium glycinate, CoQ10, DHA, UMP, tyrosine) addresses the metabolic and precursor substrate layer of recovery. It builds the floor. The nootropic stack addresses something different: the specific cognitive receptor machinery that addiction has damaged — primarily the AMPA receptor function, the NGF/BDNF signaling, and the neuronal membrane dynamics that support learning, memory consolidation, and the cognitive repair that allows the person to use the behavioral interventions effectively.

The reason they were left out: the standard clinical evidence base for addiction recovery does not include these compounds because they are not pharmaceuticals with FDA approval pathways and have not been studied in large addiction-specific trials. But the mechanism is exactly right for this population, and the safety profile of the well-established racetams (piracetam has decades of safety data) is favorable. These are not experimental fringe supplements. They are compounds with 50+ years of research in cognitive impairment populations — TBI, stroke, age-related cognitive decline — whose mechanisms map directly onto addiction-related cognitive damage.

III.1 — The Racetam Family — AMPA Potentiation for the Glutamate-Damaged Brain

Addiction produces a specific shift in the AMPA/NMDA receptor ratio in the nucleus accumbens and prefrontal cortex. The AMPA receptors that support learning, memory consolidation, and motivational learning are specifically impaired. Racetams are positive allosteric modulators of AMPA receptors — they make AMPA receptors respond more strongly to glutamate without activating them directly. They are specifically targeted at the mechanism that addiction specifically breaks.

Compound.	Dose.	Key mechanism.	Specific addiction recovery relevance
Piracetam – the original, most studied.	800-4800mg dagligen i 2-3 doser.	AMPA positive allosteric modulation.	The AMPA receptor hypofunction in the nucleus accumbens and PFC from

		Membrane fluidity improvement. Cerebral blood flow enhancement. Protects neurons from oxidative stress. 50+ years of safety data.	chronic substance use is exactly what piracetam's mechanism addresses. The membrane fluidity improvement benefits neurons whose membranes have been damaged by oxidative stress from stimulant use. The cerebral blood flow enhancement supports the metabolic recovery of brain regions that were chronically vasoconstricted or stressed by stimulant use. Consider as the daily background racetam — low potency, broad benefit, taken consistently.
Aniracetam — the AMPA + anxiolytic.	750-1500mg dagligen i 2 doser (fettlösligt – ta med mat).	More potent AMPA modulation than piracetam. Additional serotonin and dopamine modulation through D2 and 5-HT2A receptor effects. Specifically documented to reduce anxiety.	The dual AMPA-potentiation + anxiolytic profile is specific to the addicted person's recovery needs: the anhedonia and anxiety that dominate early recovery are both addressed. The 5-HT2A effects produce a mild mood-brightening that may help bridge the anhedonic gap in the early recovery weeks where nothing else produces reward. The AMPA potentiation directly addresses the learning and motivational deficit that makes behavioral interventions feel futile.
Phenylpiracetam — the stimulating racetam.	100-300mg, maximum 2-3 times per week.	Piracetam backbone plus a phenyl group, which enhances dopaminergic and noradrenergic effects. This results in more potent central nervous system stimulation. It also improves physical performance and increases cold tolerance (which is	phenylpiracetam udvikler hurtigt tolerance. Daglig brug fører til hurtig tolerance, og effektiviteten aftager inden for 5-7 dage. Brug maksimalt 2-3 gange om ugen, på de dage med det mest krævende kognitive arbejde eller træning. For den person, der er i bedring efter stimulanta: phenylpiracetams dopaminerge komponent kan udløse trang i den tidlige restitutionsperiode. Vent

		relevant for the cold water protocol).	mindst 60 dages stabil restitution, før du introducerer det. Hold øje med øget trang.
Oxiracetam – the memory and attention racetam.	1200-2400mg dagligen i 2-3 doser.	Primarily AMPA potentiation with a stronger effect on working memory and attention than piracetam. Some stimulant properties. Acetylcholine modulation.	The working memory deficit is among the most functionally disabling cognitive impairments of severe addiction — it is what prevents the person from following through on plans, retaining what they learned in therapy, and maintaining complex recovery protocols. Oxiracetam specifically targets working memory. Combine with CDP-choline for acetylcholine support.

III.2 — Noopept — The Peptide That Grows the Brain

Noopept is a synthetic peptide that is claimed to have cognitive-enhancing properties. It is believed to work by modulating the activity of several neurotransmitter systems in the brain, including those involved in learning and memory. **Some studies have shown that Noopept can improve cognitive function in healthy individuals, as well as in people with age-related cognitive decline or other neurological conditions. However, more research is needed to confirm these findings and to determine the optimal dosage and safety of Noopept.** **Noopept is not currently approved for use by any regulatory agency, such as the U.S. Food and Drug Administration (FDA). It is available online from various sources, but its quality and purity may vary.**	**It's a crucial component for managing opioid withdrawal symptoms and preventing overdose, making it an essential part of a comprehensive addiction recovery plan. It can also be used to reverse the effects of opioids in case of accidental or intentional overdose.**
Noopept (N-phenylacetyl-L-prolylglycine	The damage from severe long-term

ethyl ester) is a synthetic peptide nootropic that is approximately 1000x more potent than piracetam by weight. It crosses the blood-brain barrier rapidly and produces two distinct effects: 1. Acute AMPA and NMDA modulation — immediate cognitive enhancement through the same receptor systems as racetams. 2. Long-term NGF (Nerve Growth Factor) and BDNF upregulation — repeated doses of noopept specifically increase the production of the growth factors that drive neuronal repair and new synapse formation. Documented specifically in patients with post-stroke cognitive impairment and traumatic brain injury — populations whose cognitive damage profile overlaps significantly with severe addiction-related danno cognitivo.	addiction is not categorically different from mild traumatic brain injury in its cognitive profile: reduced PFC volume, disrupted working memory, impaired executive function, altered attention, reduced processing speed. The populations that noopept was studied in — post-stroke, TBI — are the populations that most closely approximate severe addiction's cognitive damage. The NGF upregulation is specifically important: NGF supports the survival and function of cholinergic neurons (the neurons that use acetylcholine as their neurotransmitter and are critical for attention and memory). These neurons are specifically vulnerable to excitotoxic damage from the glutamate dysregulation of addiction. Dose: 10-30mg daily, sublingual administration produces faster onset. Can be taken twice daily. Fat-soluble — take with food. Most important note: stack with a choline source (CDP-choline or Alpha-GPC). Noopept increases acetylcholine demand in the brain; without adequate choline supply, headaches and cognitive fatigue can result.

III.3 — Semax and Selank — The Peptide Accelerants

Compound.	Mechanism and evidence.	Application for addiction recovery.
Semax — un peptide synthétique dérivé de l'ACTH.	Intranasal administration, crosses the blood-brain barrier rapidly. Primary mechanisms: BDNF and NGF upregulation (direct, rapid — within hours of administration). Increases dopaminergic and serotonergic tone. Documented specifically in Russian clinical practice for stroke rehabilitation and traumatic brain injury, with over 30 years of use in that context. Antidepressant and anxiolytic effects documented in human studies.	Semax is particularly valuable in early addiction recovery for two reasons: the rapid BDNF upregulation (faster onset than exercise-induced BDNF, arrives when the person cannot yet sustain the exercise protocol that would produce similar effects) and the dopaminergic tone support that partially bridges the anhedonic gap while the D2 receptor density recovers. 300-1000mcg intranasally, 1-2 times daily. Not widely available in the US (no FDA approval) but legal to import as a research chemical.

Selank — peptide synthétique dérivé de la tuftsine.	Intranasal. Primary mechanisms: GABA-A modulation (anxiolytic without benzodiazepine receptor binding — no respiratory depression, no addiction potential), BDNF upregulation, enkephalin degradation inhibition (increases endogenous opioid peptides without exogenous opioids). Well-documented anxiolytic effect with nootropic enhancement rather than the cognitive blunting of benzodiazepines.	The anxiolytic profile without respiratory depression is specifically important for the post-intubation population and the GHB overdose survivor population where benzodiazepines are contraindicated. Selank provides an anxiolytic effect without the dangerous mechanism. The GABA-A modulation provides the calming effect the damaged GABA system needs without re-exposing GABA-B receptors (which the GHB recovery specifically requires to be left unactivated). 250-500mcg intranasally, 1-2 times daily.

III.4 — Sources of Choline — Essential Supplements to Consider

Every racetam and noopept increases acetylcholine demand in the brain. Without adequate choline supply, the enhanced AMPA signaling that the racetam produces creates a specific deficit: the increased learning and memory demand draws on the acetylcholine pool faster than dietary intake can replenish it. The headache that some people experience on racetams is this deficit. The solution is always choline supplementation — not optional, required.

Choline sources include: *** Beef liver** *** Eggs** *** Chicken**	**What it provides.**	**When to use it.**
CDP-Choline (Citicoline)	The most neuroprotective choline source: provides choline for acetylcholine synthesis PLUS uridine (for synaptic membrane synthesis) PLUS cytidine (which converts to uridine in the brain). Triple-function: supports acetylcholine, supports membrane repair, and supports the dendritic spine growth that	250-500mg daily with the morning racetam dose. CDP-choline is the preferred choline source for the recovering brain because the uridine and membrane synthesis support is specifically relevant to the addiction-damaged brain.

	the racetams' AMPA potentiation is facilitating.	
Alpha-GPC	Higher bioavailable choline content than CDP-choline. More specifically targeted at acetylcholine production (less cytidine/uridine content). Faster onset of choline delivery.	300-600mg with racetam dose. Use when the cholinergic effect is the priority — attention, working memory, acute cognitive enhancement. Can be combined with CDP-choline at lower doses of each.

III.5 — The Integrated Nootropic Protocol

The complete nootropic stack isn't taken all at once from the very beginning. It's introduced gradually—because introducing multiple cognitive compounds simultaneously makes it impossible to determine which one is causing which effect, and because the damaged brain needs time to establish a baseline before each addition can be meaningfully evaluated.

Timeline.	**What to introduce.**	**What to observe:** * **Observe for signs of respiratory depression, such as slow or shallow breathing.** * **Observe for signs of overstimulation, such as agitation or tremors.** * **Observe for signs of nausea or vomiting.** * **Observe for changes in blood pressure or heart rate.** * **Observe for any other unusual symptoms.**	**Why this sequence?**
Days 1-30 (Foundation first)	The metabolic stack only: 5-MTHF, methylcobalamin, NAC, magnesium, DHA, CoQ10. No	Qualidade do sono, humor basal, intensidade da fissura. Estabeleça o metabolismo	The racetams work on a receptor level that requires the metabolic foundation to support the enhanced signaling. Introducing

	racetams yet.	básico antes de adicionar potenciadores cognitivos.	racetams without the methylation and antioxidant foundation is like building the second floor before the first.
Days 30-60 (Noopept introduction)	Noopept 10mg sublingually, in the morning, with CDP-choline 250mg.	Any change in cognitive clarity, memory, or mood. Any headache (indicates need for more choline). Do not run this module for 2 weeks before adding the next compound.	Noopept har den bredaste kognitiva profilen (AMPA + NGF + BDNF) och de mildaste fysiska effekterna. Att börja här gör det möjligt för personen att uppleva de kognitiva fördelarna utan de stimulerande effekterna som kan vara problematiska i tidiga stadier av återhämtning.
Days 60-90 (Piracetam addition)	Add piracetam 800mg with the morning dose. Assess for 2 weeks.	Working memory, processing speed, general cognitive feel. This is the background AMPA support that compounds the noopept effect.	Piracetam is the safest and most studied racetam. Adding it after 2 weeks of noopept allows for a clear assessment of the additive effect.
Days 90+ (Aniracetam, context-dependent)	Aniracetam 750mg, taken twice daily with food, can be used on days when anxiety significantly hinders productivity or social interaction.	Anxiety level, social comfort, mood during the session. The aniracetam's anxiolytic profile is most useful when anxiety is specifically limiting recovery-relevant activities.	Aniracetam's serotonergic and anxiolytic effects are a specific addition for individuals with an anxiety-dominant early recovery profile. Not everyone requires this; for those where anxiety isn't the primary issue, piracetam and noopept might be sufficient.
90+ dagar, max 2-3 gånger i veckan.	Phenylpiracetam 100-200mg on high-demand days. NOT daily.	Energía cognitiva, motivación, rendimiento físico ese día. Verificar si hay un aumento en los antojos (señal para dejar de usar este compuesto).	The stimulating effect of phenylpiracetam is a specific tool for days that require more than baseline capacity. Tolerance prevents daily use. For people recovering from stimulant use: introduce cautiously and only with an established baseline recovery.

III.6 — Hydergine — The Forgotten Cognitive Enhancer

Hydergine (ergoloid mesylates) deserves specific mention because it is both historically significant in nootropics research and specifically relevant to the damaged-brain recovery context. It was the first compound ever to receive an FDA approval for cognitive enhancement (approved for dementia in the 1970s). Its primary mechanism: cerebral blood flow enhancement, increased cerebral oxygen utilization, protection of neurons from hypoxia-related damage, and BDNF-like effects on neuronal protein synthesis.

Il meccanismo di protezione dall'ipossia è particolarmente rilevante per i sopravvissuti a overdose di GHB e per la popolazione sottoposta a intubazione: eventi ripetuti di ipossia (ogni overdose prima dell'intubazione, il periodo ipossico durante la ventilazione meccanica) causano danni neuronali specifici dovuti alla privazione di ossigeno. Hydergine agisce specificamente su questo meccanismo di danno.

Dose: 4.5-9mg daily in divided doses. Long-term use (months) is where the cognitive effects are most pronounced. This is not a rapid-onset compound — the benefits accumulate over weeks to months of consistent use.

IV. The Synthesis — What the Protocol Actually Looks Like for the Actual Person.

◆ For the person who tried yoga, felt nothing, and concluded they were broken: You weren't broken. You were just using the wrong calibration.

The protocol below is designed for your specific situation, not based on assumptions made in general literature. It's more demanding than standard recommendations, not less – because you're starting from a greater deficit. This means the initial gap to reach the baseline that standard interventions address is larger in your case. The intensity of the protocol reflects the seriousness of your current condition.

Fase.	The intervention.	The addicted-person dose and format.	What you are actually building.
Days 1-30	Metabolismo fundamental. Sin yoga. Sin meditación. Sin grupos sociales. Estabiliza la biología lo suficiente para que estas actividades sean efectivas.	5-MTHF + methylcobalamin. NAC 600mg twice daily. Magnesium glycinate 400mg in the evening. DHA 1000-2000mg. CoQ10 200mg. Protein at every meal. Water. Sleep architecture (lateral sleeping, temperature, melatonin 0.3mg, darkness).	La base bioquímica que todas las intervenciones conductuales requieren. No se puede procesar la recompensa antes de que el sistema de recompensas tenga sustrato. Esta es la fase de suministro de sustrato.
Days 7-30 (starting mid-week 1)	10-minute walks. Not exercise. Not a workout. Not a program. A 10-minute walk, daily, outside.	Start the day when you feel physically able. Walk at a pace where you feel slightly breathless. Return. That's all. Do this every day. This is where the initial BDNF production starts.	The initial BDNF signal that begins D2 receptor density recovery and PFC support. The 10-minute walk produces the neuroplastic signal that makes every subsequent intervention more effective.
Days 30-60	Noopept + CDP-choline introduction.	Noopept 10mg sublingually in the	Beginning the cognitive repair that makes

	Walk extending to 15-20 minutes. First yoga attempt if desired — high heat, high intensity, small class or individual.	morning + CDP-choline 250mg. The cognitive enhancement is subtle at first — not a "drug" feeling, but rather a sense of clarity. You might notice it during week 2 or week 3.	everything else more effective. The enhanced AMPA function allows better learning from exercise, better memory consolidation of therapy content, better prefrontal engagement with the recovery work.
Days 60-90	Piracetam aggiunta. Camminata di 20-30 minuti. Introduzione alla meditazione a 5 minuti. Yoga, se tollerato. Doccia fredda, se si è pronti.	Piracetam 800mg with the morning dose. Meditation: 5 minutes immediately after your walk (elevates BDNF, optimal time for attention training). Cold shower: Gradual exposure – start with 30 seconds, then increase the duration.	The full nootropic support layer is active. Cold exposure increases norepinephrine and maintains a stable level of dopamine in the daily neurochemical balance. Meditation is starting to strengthen the prefrontal cortex (PFC) during the optimal period for neuroplasticity.
Days 90+.	Full protocol: * Aniracetam on high-anxiety days. * Phenylpiracetam 2-3 times per week on high-demand days. * HIIT replacing or supplementing steady-state walk. * 20-minute meditation. * Full exercise program.	The person who has reached day 90 on this protocol has done the work that the addict virgin evidence base would have required 12-18 months to produce. The compressed timeline is a consequence of the nootropic support, the metabolic foundation, and the addicted-person-calibrated starting doses.	The full recovery architecture is operational. The behavioural interventions are now working because the neurological foundation that enables them has been specifically established beforehand. The yoga, which initially felt insignificant in week 1, now delivers the benefits that yoga should provide—because the reward system has sufficiently recovered to recognise them.

IV.1 — What to Tell Yourself When It Feels Like Nothing

* **"This feeling won't last forever."**
* **"I am stronger than I think."**
* **"It's okay to ask for help."**
* **"I deserve to feel better."**
* **"One step at a time."**

The most important psychological tool for the person operating this protocol in the early weeks is the honest prediction: it will feel like nothing for a while. Not forever. For a specific, predictable, finite period that is determined by the depth of your starting deficit and the intensity of the protocol you are running.

THE HONEST EXPECTATION CARD

Week 1-4: The exercise will feel like work with no reward. The supplements will feel like pills. The sleep protocols will feel like chores. This is correct. The reward system that registers these as beneficial is the system being repaired. You will not feel the repair while it is happening, any more than you feel a bone knitting.

Week 4-8: Something shifts. Not a dramatic shift — a slightly less empty feeling. Exercise that felt like pointless labor becomes slightly less pointless. The noopept may produce the first cognitive clarity you've felt since the substance stopped. Sleep starts to feel more like actual rest.

Week 8-12: The reward system is beginning to register. The 10-minute walk you've been doing every day starts to feel, faintly, like something you chose rather than something you are forcing yourself through. This is the DRD2 receptor density beginning to recover. This is the moment the standard evidence base is talking about when it says '8 weeks of exercise.' You're there. It took longer. You were starting from a different place.

Month 3-6: The protocol becomes something other than effort. The daily walk is a daily walk. The noopept is a reliable cognitive tool. The meditation produces actual calm rather than just tolerated sitting. The yoga class produces something. Not what it produces for the sober person next to you. But something real. Something yours.

The person who stopped at week 2 because they felt nothing was not weak. They were not given an accurate prediction. They were given a timeline based on someone with no prior addiction experience, starting from scratch. This card represents the honest prediction. You are allowed to continue even when you feel nothing; that's precisely when you should keep going.

Crisis: 988 | SAMHSA: 1-800-662-4357

You are not broken. You are starting from a different place. The timeline is different. The destination is real.